FOCUS GROUP
ON
SUICIDE PREVENTION

EXECUTIVE SUMMARIES

JUNE 1995

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PREAMBLE

These Executive Summaries are designed to help First Nations people deal with the problem of suicide in their communities. They are the result of ten informative presentations and the subsequent discussions by a Focus Group on Suicide Prevention. The Focus Group members presented papers that dealt with suicide prevention, within the context of their own training and backgrounds. Nine of the twelve presenters are Aboriginal professionals, as are the chairperson, workshop leader, and the physician who wrote the concluding remarks. They met at Spencer Hall Conference Centre, University of Western Ontario, in London, Ontario, on June 24 and 25, 1995.

Part I discusses the history of First Nations communities, beginning at the time of their first contact with Euro-Christian culture. It also presents some national suicide statistics, gives us a profile of the suicidal person, and elaborates on some common myths and reasons for suicide.

Part II acquaints us with mental disorders, and compares yesterday's tribal family structure to today's single-parent family structure.

Part III gives us some practical counsel on how to deal with the individual who is suicidal, how to work with families who are in trouble, and how to act as catalysts and motivate our own communities to form crisis-response teams.

Part IV provides us with closing remarks and recommendations.

Appendix A lists some suggested readings on suicide prevention, and Appendix B lists and acknowledges the presenters, as well as the other participants in the Focus Group on Suicide Prevention.

Individual First Nations communities will have different concerns, which may not have been dealt with in this document. This document is a guide and a source of information only. It is a working tool. There are blank pages throughout the book so that each community can add its own notes.

INTRODUCTION

The Brighter Futures Initiative was introduced by the Minister of the former Department of National Health and Welfare in May 1992. It continues to provide funding, to ensure the continuity of already existing programs in Native communities, and to encourage community action.

In February 1995, a group of front-line practitioners, Aboriginal clinical psychologists, youth delegates, and Medical Services Branch staff met in London, Ontario to discuss suicide prevention in Aboriginal communities. The result was a document entitled "Discussion Notes from the Suicide Prevention Workshop".

In June 1995, a second workshop was organized and funded by Health Programs Support Services from the Medical Services Branch of Health Canada to meet in London, Ontario, once again. It brought together professionals from across Canada. They made presentations, and discussed suicide in Aboriginal communities at length. They focussed on their own experiences, and suggested ways of dealing with suicide in Native communities. This document represents the highlights of the presentations, panel discussions and key issues that emerged.

For a copy of the full presentations delivered at the Focus Group on Suicide Prevention please contact:

The Native Psychologists in Canada
1750 Alta Vista Drive, Suite 103
Ottawa, Ontario K1G 3Y6

PHILOSOPHY

Suicide is a serious problem in our Native communities. It has reached epidemic proportions. It is the final self-destructive act of despair, committed while in a state of hopelessness and depression.

The hardest hit are our young men between the ages of 15 and 24. They are unable to find meaning in their lives. They feel abandoned by their culture and rejected by the larger society. They turn to substance abuse to ease their pain and frustration, and, in the process, simply worsen their mental state.

Many of our communities are in a constant state of mourning because of the high rate of suicides, accidental deaths, and violent deaths. Families and friends of the deceased get depressed, and may ultimately attempt suicide themselves. Outside organizations and qualified individuals can be invited to help in such situations.

We need to focus on suicide prevention in our Native communities. The best solutions will come from within ourselves. We must break the cycle of abuse, denial, and despair, and develop healthy communities by introducing programs that reinforce mental and physical health. We need to deal with the underlying problems that create crisis situations; prevent substance abuse and neglect of children; and, improve our recreational activities. Some of us must be made aware of our Native culture. We need to develop health curricula in our schools to teach confidence, self-worth, and coping skills.

Through a comprehensive, holistic approach, we need to teach others about cultural values, good family life, and health education. We need to set up healing programs and manage them ourselves. Local band councillors, front-line workers, and individual community members are in the best position to find creative solutions that will work.

Many communities have organized healing and talking circles with trained professionals. They draw on the traditional teachings of Elders and on ceremonies. Other communities have adopted the culture of the larger society. There is no one single solution that will work for all communities. Our peoples are all very different. We can only work from within our own communities to build stronger and healthier children. They are the ones who will lead us into a brighter future.

VALUES

- The role of every individual in a community is to encourage and support suicide-prevention programs and services which are in keeping with cultural values, lifestyle, language, and traditions.

- It is the responsibility of all individuals in a community to create and sustain a healthy and caring environment, one that will foster awareness of problems where they exist, and will develop programs and services for people who are in need.

- We recognize that a community is healthy only when the individuals and families in it are physically, mentally, emotionally, and spiritually healthy.

- We believe that communities know their own needs, and that they are in the best position to develop their own suicide-prevention programs and services.

PART I

BASIC CONCEPTS OF SUICIDE

Aboriginal Concept of Suicide

by Cecil King, PhD
... presented by Margaret Sebescen, BA

"To self-kill is to turn your back on your traditions and the people who are your teachers, and thereby show a disdain for your own society. You let them down. We cannot support people who commit suicide in their journey into the Land of Souls."

Before contact with Europeans, suicide was extremely rare among the traditional cultures of North America. All the traditional philosophies reinforced and celebrated life.

Language expresses how we interpret the world and it tells us a great deal about our culture. The Ojibwe language is rich in metaphor and comparison, and important actions are often discussed using stories and examples. The Ojibwe language has no word to express the act of taking one's life. To the present day, Elders struggle for words when telling of a suicide.

Traditionally, death was seen as a natural part of the life cycle. If death came easily, the community rejoiced. If a person lingered on in sickness, the community became alarmed and helped the lingering soul set his life in order so that he could enter the Land of Souls. The Land of Souls is described as a place where food and drink are plentiful and good, where there is music like the songs of yellow birds, and where winters are temperate.

Suicide was the most upsetting form of death for the Ojibwe people. Relatives showed great emotion. At the time of mourning, the departed person's name was not mentioned and explanations came only after the burial. People then expressed the opinion that witchcraft was involved, and various signs were used to support this explanation. The possibility of intervention from other-than-human forces was more in keeping with the Ojibwe view of the world.

The Christian Old and New Testaments do not condemn suicide, but during the 4th century, Saint Augustine stated that suicide violates the sixth commandment, Thou shalt not kill, and during the 7th century, the Council of Toledo proclaimed that a person who commits suicide is excommunicated. In the 13th century, Saint Thomas declared that suicide is a mortal sin because it denies God the power over life and death. That view has had an enormous impact on western behaviour and thought.

Traditional Native and Euro-Christian views on self-killing are not that different. Life is seen as predetermined by the Creator, and to replace the Creator's role in the termination of life is not normal behaviour.

Anishnabe teachings and philosophy, however, differ sharply from Euro-Christian teachings. Anishnabe teachings set out what constitutes a good life, a good person, and good behaviour. They also paint a picture of our relationship with the Creator, the plants, the animals, other human beings, and other-than-human forces. The Enendahgwad (Law of the Orders) forms the basis of how the Ojibwek, the Odawak, and the Pottewatomeek see the world. According to the Law of the Orders, human beings are the least necessary and the most dependent of all Orders. The plant and animal Orders can survive without them, but they cannot survive without the plants and animals.

Euro-Christian teachings place human beings next to God in the order of creation. Humans are seen as having dominion over other forms of life. Other-than-human forces are not acknowledged, except in the person of the one true God. Spirits are viewed as evil forces.

Europeans, at the time of contact, viewed their beliefs as superior to other doctrines. They had a mission to elevate those with other beliefs to a higher form of spiritual life. This brought many Anishnabek into conflict with the fundamental principles of their existence. The Euro-Christian view left no room for other philosophies.

For too many Anishnabek, the choice became a denial of their Anishnabe ways and the undermining of their basic ways of life. Their resolve to live became compromised, and suicide became an alternative.

Panel Discussion

The introduction of Christianity caused much confusion and raised many questions in the Native population. Some people lost their traditional ways and replaced them with Euro-Christian values. Others still observe traditional ways today. Both sets of beliefs exist side-by-side, and they create grave conflict, even within families.

At times, when we look at our youth on a reserve, we see not a conflict of values, but an absence of values. Many young people are lost. Some children believe there are only bad spirits. There is much confusion. We need to speak of good guiding spirits with our children. We need to lead ceremonies that help balance out our lives and the lives of our youth. The healing system is a complete one, and ceremonies go to the heart of tradition.

THE EPIDEMIOLOGY OF SUICIDE IN ABORIGINAL PEOPLE: A NATIONAL VIEW

... by Charles Mustard, MD and
Ellen Bobet, MA (Health Canada)

"The purpose of science is not to study the world, but to change it."

Suicide is a major health concern in First Nations' communities in Canada. Based on data collected by Medical Services Branch[1]:

- Suicide rates among Status Indians in Canada are 2-3 times higher than the rate for the whole population of Canada. In 1992, 162 suicides were reported.
- The suicide rates for Status Indians are highest in the age group 15-24, and decline thereafter with age. By comparison, for the non-Native population, suicide rates remain relatively constant throughout adulthood and do not show the same peak among 15-24 year olds.
- Men are about three times as likely as women to commit suicide. In contrast, women are twice as likely as men to attempt suicide.
- There has been no clear sign of change in the suicide rate among Status Indians in the period 1979-1992. There is considerable year-to-year variability, which may reflect suicide clusters.
- From 1989 to 1992, the following methods of suicide were most frequent: hanging (45%); firearms (33%); drug poisoning/overdose (13%); and, other methods (9%).

[1]Data collected by MSB cover approximately 78% of the Status Indian population of Canada. The data suffer from some limitations of coverage and accuracy, but are nonetheless the most complete source of national data available.

- Reports from one Medical Services Branch Region suggest that there are about 10 suicide attempts for each completed suicide.

- Factors associated with suicide attempts in one Regional study included: involvement of alcohol/drugs/hair spray; history of previous suicide attempts; death of a family member or friend; history of sexual abuse; and, family violence.

National data may conceal substantial variation among communities and regions of the country.

PANEL DISCUSSION

National data are not very useful at the community level. These generalizations conceal wide variations in the local and regional Aboriginal suicide experience. In some places, suicide rates are high. In others, they are low.

In Alaska, suicides occur mainly between November and March, when there is no sun. This would surely have a bearing on the data. Housing, cleanliness, and certain standards may also have a bearing on the data. There is a need for regional data collection. Also, regional time and geography analyses would be useful in analyzing clusters (commonly referred to as copycat suicides).

Key Issues

- Language plays a very important role in our lives. We need to learn our own language in order to express our own values.
- We need to learn more about the history of conflict between the traditional and the Euro-Christian cultures and to teach others about what we have learned.
- We must strive to be tolerant of other people's beliefs. Traditional values live side-by-side with Christian values in our communities today.
- Traditional and Euro-Christian views on suicide are similar. We can all work together to come up with solutions and suggestions for suicide prevention.
- We need to collect our own regional data and to analyze it. This may help us to find ways of dealing effectively with suicide.

Sociological Factors Associated with Suicide

... by Brenda Restoule, MA

"Suicide rates are relatively low in communities that are more traditional. We need to develop a strong Native identity to survive."

The reasons for suicide in Aboriginal communities are complex. Before we can prevent a suicide from occurring, we must first look at our history. Then we need to find out who is at risk in our own community.

Aboriginal people ceased to live off the land as hunter-gatherers because the land was taken from them by European settlers. They were eventually relocated to reserves and forced to depend on the larger society's social welfare system for survival. Native men were no longer seen as providers. They were made to feel inadequate. This situation led to a number of problems, such as alcohol abuse, poor housing, poor hygiene, and community disorganization.

With the breakdown of Aboriginal culture and social structure, the people turned to the culture of the larger society only to find that they did not possess the skills necessary to become part of that society. They experienced discrimination and racism. Although Aboriginal people were being urged to assimilate into the larger society, they were also being pressured to remain true to their native culture and heritage.

Native men experienced a loss of personal power, that inner balance and toughness of mind that allows a person to bounce back from disasters. They lost the ability to establish and maintain caring relationships as well as to take care of themselves and others, since this is learned behaviour and they were separated from their families and communities and sent to residential school at a very young age. Finally, they lost their traditional knowledge and skills.

Today, our young people feel alienated from the larger society because of their race, lack of education, and language difficulties. They also feel alienated from their own culture because of separation, family disruption, absence of traditional culture, and an inability to communicate with Elders.

People who are suicidal tend to be single, separated, divorced, or widowed. They also tend to live alone. They are often described by others in the community as withdrawn. They have inadequate social contact, and are more vulnerable to stress. This isolation from others begins in childhood and persists through adolescence and adulthood. Often, they attempt suicide many times before they actually complete the act. They speak of their intent with what family and friends they have. Each attempt becomes increasingly more dangerous.

Suicide clusters (commonly known as copycat suicides) occur when there is a crisis in the community. The victims are not always related, but they all believe that suicide is the only way out of a situation. They may also believe that they are going to a better place after death. This is very attractive to them. The media can play a role in clusters by focussing on the original suicide and portraying it as a heroic act.

When there are periods of cultural change due to contact between two distinct cultural groups, people in the minority group adopt one of four attitudes. **Integration:** They choose to maintain their own culture, while adopting some attitudes of the larger society. **Marginalization:** They do not wish to participate in their own culture, and they do not feel accepted by the larger society. **Assimilation:** They adopt the attitudes and customs of the larger society, and reject their own culture. **Separation:** They wish to maintain their own culture, and have no desire to adopt the attitudes of the larger society.

Durkheim proposed three types of suicide: egoistic, altruistic, and anomic (Davenport & Davenport, 1987; Armstrong, 1985). Anomie most likely accounts for the high suicide rate in Aboriginal communities. This type of suicide occurs when there is a period of social change, causing a lack of governing forces in our lives.

The stress brought on by this process of change diminishes physical, mental, and social well-being. Cultural norms that once provided meaning and guided individual behaviour become meaningless. The person feels abandoned, bewildered, and unsure of the meaning and purpose of life. All of these factors increase the risk of suicide.

PANEL DISCUSSION

The young people on our reserves feel that they do not belong in either culture. Some of them have developed a culture of their own. As a result, we now have satanic cults and far-out churches. This is an adolescent response to alienation. We all have a basic need to belong. Our Elders are right when they say that videos and rock music often cause problems with our youth. Young people try to copy what they see and hear. Their view of the world has not yet been formed.

In the more traditional communities, the suicide rate seems to be lower. This may be because the way young people view the world is consistent. Their self-esteem is high. If a person is allowed to develop a strong Native background, he or she will adapt and change as new challenges arise. Outside the community, or in weak traditional communities, the negative attitudes of the larger society are adopted.

Aboriginal people are profoundly spiritual. We are more than the end result of our environment. We have a strong connection with the Creator and with our spiritual heritage. There is an indefinable quality which makes us truly Micmac, Ojibwek, or Anishnabek. We have experienced hard times. We have suffered. Now, we need to heal.

THE PSYCHOLOGY OF SUICIDE – A LETHAL PERSONAL STATEMENT

... by Dianne Tanner, MA

"Suicide is the solution to a problem. It is not a random, illogical, or pointless act."

Suicide is a personal statement. It reveals an individual's state of mind at the time of death. It is the ultimate solution to a serious problem. The person who chooses death over life is undergoing intense suffering, because of the way he or she is experiencing a situation. The common reason people commit suicide is to escape from unendurable psychological pain. Studies have shown that we can help them by reducing their level of suffering, even just a little bit. It is a purposeful act. It is not random, illogical, or pointless. Often, people fear that their situation will get out of hand and become uncontrollable. Suicide is viewed as an alternative to madness.

Human beings have various needs. When these needs are not met, suicide becomes an answer. Many emotions are present in suicidal people. However, there is one emotion which goes to the very core of the problem in our communities, and that is the feeling of hopelessness or helplessness.

The suicidal person is of two minds. He or she feels that it must be done, yet wants to be rescued. There are many things we can do to help reduce a person's suffering. We can listen and talk to the person, we can contact agencies equipped to deal with suicide, or we can call the person's family and friends.

Some common myths surrounding suicide are: it is an act of rage, hostility, or destruction; it is an act of withdrawal; people who talk about it don't do it; no one can stop a person who really wants to do it; and, suicidal people are mentally ill.

People who commit suicide leave clues about their intention. These clues may be verbal or behavioural. Verbal clues are statements which indicate leaving. For instance, a person might say: "I'm leaving here." or "Don't try to get in touch with me because you won't see me around anymore." or "I don't want to live anymore." or "I'm going to kill myself." Behavioural clues consist of getting things organized or putting things in order. For instance, a person might give away his or her favourite items, buy pills or a gun, or behave in a manner which is unusual. It is up to us to recognize these clues, and offer friendship and assistance.

Some reasons for profound intrapersonal (within the self) psychological pain are: loss of prestige, job, money, or status; a criminal charge; or, a physical illness. Some reasons for severe interpersonal (with others) pain are: divorce, death, separation, or involvement in an accident.

All depressions do not lead to suicide. We can learn more about the various elements of depression, however, to increase our chances of intervening and preventing suicide.

Some **physical signs** of depression are: too little or too much sleep, an increase or a decrease in appetite, a marked change in body weight, and fatigue and anxiety. Some **mental signs** are: confusion, a negative self-evaluation, an inability to concentrate, an inability to make decisions, and an onset of suicidal ideas. Some **emotional signs** are: loss of a sense of humour, overwhelming guilt or remorse, loss of motivation, feelings of powerlessness, and an increase in irritability or anger. Some **behavioural signs** are: acting out or giving up, a start or an increase in substance abuse, and frequent crying spells. There may also be destructive or aggressive acts, with an increase in compulsive behaviour. On the other hand, the depressed person may withdraw or become a perfectionist. In relationships, the person may show a marked dependency on another person, be overly responsible for another, seek excessive approval, or be very critical. The person may have destructive fantasies or images, experience recurring nightmares, and be overly involved with spiritual rituals, interpretations, and cults.

We need to learn more about the ways in which people communicate their distress, the ways in which they drop clues about their mental state. Only then will we be able to prevent suicide.

Even if the psychological element is at the core of suicide, we must approach the issue from many different angles. The community plays a crucial role in this approach. We need to educate ourselves and others in the skills required to deal with suicide prevention. By offering our support and love, by helping others, even if only by listening, we can heal ourselves and contribute to the well-being of our community.

Panel Discussion

There are no easy answers. We must be very careful about labeling people as crazy or on drugs. Some of our people sense a world around us which others cannot imagine. Our sweat lodges raise the body temperature to such a point that chemical reactions occur at times. This leads to states of altered consciousness. This openness and willingness to let ourselves experience the larger world around us goes to the heart of our tradition. In our own languages, we can speak of spirits and ghosts with ease. The English language does not lend itself readily to the idea of the spirit world.

Communication is extremely important. We have all heard people say: "For the first time, I felt as if someone really cared." There is something missing in the life of a person who is contemplating suicide. There is some need which has not been fulfilled. That need may be as simple as another person who will listen.

We must learn and teach others what to do in a situation where someone expresses suicidal tendencies. Our schools need to develop suicide-prevention curricula. We do not need specialized degrees to help someone in distress. We need compassion and a willingness to take the time to listen and help out in whatever way is best. We must not try to gloss over the problem or blur it with such issues as confidentiality. This is a Euro-Western concept. There is little doubt that everyone in a small community knows everyone else's business. Let us get past that, and work toward a more traditional life, a life based on mutual respect.

KEY ISSUES

- Suicide rates seem to be lower in traditional communities. We need to find out more about our Native heritage.
- We need to learn more about our traditional ways and values, and teach them to the young people in our communities.
- We need to let our strong connection with the Creator and with our spiritual heritage guide us in everyday life.
- Suicidal people have ambivalent feelings about the act itself. We need to know that, and to make an effort to change their minds.
- A suicidal person is experiencing intense suffering in one form or another. We must try to alleviate that suffering, knowing that even a small decrease in suffering can change a person's mind.
- We must be attentive to the people in our community who are experiencing personal pain or depression due to loss or injury.
- We need to learn more about the ways in which people communicate their distress, the ways in which they drop clues about their mental state.
- We need to learn more about traditional healing methods in suicide prevention.
- Our schools need to develop suicide-prevention curricula.

NOTES

PART II

RISK FACTORS

Mental Disorders as a Risk Factor in Suicide

... by Bruce Handley, PhD

"Any program that aims to reduce suicide attempts in a community must include a strong element to help people cope with mental disorder."

Research into the area of Aboriginal suicide is not well documented. There are many approaches to therapy that are effective with Native people. These focus on mental disorder, low self-esteem, unhappiness, depression, and anxiety.

We inherit some physical characteristics from earlier family members, for example our father's nose or our mother's hair colour. Similarly, we inherit some psychological and emotional characteristics from them, such as our mother's good disposition or our father's sensitivity. Unfortunately, we can also inherit some serious emotional and mental problems. Alcoholism is likely to be present in several family members, and suicide is often committed by various members of the same family, even when they are raised apart.

Thoughts of suicide may occur as a result of a biological or chemical malfunction in the brain. When the brain functions properly, we feel healthy and comfortable. When it functions poorly, we feel anxious and uncomfortable, out of control, and this may lead to thoughts of suicide as an escape.

Most people who attempt suicide have some degree of one or more personality disorders.

People who have **paranoid** personality disorder feel that others are taking advantage of them. They question loyalty and faithfulness, read hidden meanings into everything, hold grudges, and react with anger to questions.

People who have **borderline** personality disorder have mood swings, unstable relationships with others, and an ever-changing self-image. They have little control over their temper, are chronically bored, and have little or no sense of purpose. They may feel abandoned if left alone.

People who have **histrionic** personality disorder display excessive emotion and seek constant attention in the form of approval or praise. They may display inappropriate or exaggerated behaviour, such as uncontrollable crying in minor emotional situations.

People who have **anti-social** personality disorder have little or no conscience and care little about the effect their actions will have on others. They are irritable, aggressive, and impulsive. Typically, they do not respect the rules of society and are unable to hold a job. As parents, they frequently abuse their children. Of all disorders, this is the hardest to treat. It is unlikely that the person will ever try to change or benefit from treatment. The behaviour is often recognized before a person reaches 15 years of age.

People who have **obsessive-compulsive** personality disorder repeat a thought or behaviour over and over again. They have recurring thoughts, images, or impulses. They are perfectionists, preoccupied with details, excessively devoted to work, and overly conscientious. They are typically neat and orderly to the extreme, have limited affection for others, and insist on things being done their way.

People who have **avoidant** personality disorder will do everything possible to avoid social situations. They are extremely shy, easily hurt, and have very few friends.

People who have **dependent** personality disorder cannot make decisions. They try to make other people like them by doing unpleasant tasks for them. They are uncomfortable when alone, and are devastated when they lose a close relationship.

People who have **passive-aggressive** personality disorder feel dissatisfied with everything and everyone. They procrastinate, become sulky when asked to do something, and respond by working deliberately slowly. They protest loudly when they feel that others have received more than they have. They firmly believe that they are doing their best, and become angry when others tell them that they could do better.

Depression may occur after a loss. Studies show that the loss of a loved one through death or divorce is one of the most stressful events we can experience. The loss of personal dignity or pride, a job, wealth, reputation, and freedom can also lead to depression. We will hear for instance: "I can't possibly face more pain." or "I'm so embarrassed I don't want to see anyone ever again." For this person, there is a higher risk of suicide.

Depression may occur due to excessive anxiety. This may result in feelings of failure, loss of control, or low self-esteem. Normal anxiety lasts for a short time only, but anxiety disorder can persist for months after the stressful event has passed. If left untreated, it can lead to phobias. These phobias are considered to be disorders only when they interfere with daily life.

Panic disorder is an episode of acute anxiety and intense fear which occurs suddenly. It lasts usually for only a few minutes, but can return in waves over the next several hours.

Agoraphobia is the fear of going out and being in crowds. It is hereditary, and is the most common phobia.

Social phobia is the fear of being embarrassed or humiliated in public, and may include fear of public speaking, blushing, choking, or spilling food.

Simple phobia is the fear of specific objects or situations. These include fear of animals, heights, elevators, airplanes, doctors/dentists, thunder/lightning, and blood.

Generalized anxiety disorder consists of persistent anxiety attacks that last for six months or more, and include the fear of losing control, of not being able to cope, of failure, rejection, disease, and death. The condition is made worse in stressful life situations.

Post-traumatic stress syndrome occurs after an unexpected accidental death or disaster. There may be repeated distressing thoughts about the event, nightmares, intense flashbacks, emotional numbness, and difficulty sleeping or concentrating, as well as a loss of interest in previously cherished things and people.

PANEL DISCUSSION

This information is very useful and will give us some insight into a troubled person's frame of mind, but we must not be too quick to label people. The western system is completely different from the traditional system, and we must not forget that the traditional system has existed for far longer.

In many cases, these labels do not apply to Aboriginal experience. Nostalgia and spirits, for instance, are culturally acceptable in some Aboriginal communities. Also, an increased awareness of historical loss might contribute to suicidal behaviour.

We must recognize that it may take time to get anywhere with suicidal people in the Aboriginal system because of this difference in attitude and thought. We need to educate ourselves and others about our Aboriginal heritage and ways of thinking. The western experience does not always translate well into our Aboriginal culture.

FAMILY ILLNESS IN TRIBAL COMMUNITIES

... by Edward Connors, PhD

"However depleted our abilities may be, we have remained strong enough to survive to see the time of healing."

Everyone in the world once lived in small tribal communities. Then, the people in the Middle East began living in large settlements which they cultivated, rather than in small (fewer than 1,000 people) nomadic tribal communities. Gradually, they developed the concept of property ownership and adopted a whole new set of values and beliefs. They contended that they had become a superior society, a "civilized" society. They gave tribal settlements no choice but to conform to their beliefs. Our people gradually moved away from tribal organization toward "civilized" society.

Tribal society was structured to maintain equality and balance in family relationships. Women took the primary role in parenting. They socialized men to develop and express their nurturing qualities within the community and their aggressive tendencies outside the community. Today, our people live in single-parent families rather than in large extended-family units. This important change in family organization has increased the power and control that men exercise in the community and in the family. They no longer have the appropriate outlets for expressing their aggressiveness outside the community, so they assert more power and control within the community and within their own families. Families today are no longer interdependent. Without the support of the community group to maintain the balance in relationships, women have lost their influence over men's socialization. This has led to a social structure based on men's aggression and their control over women and children.

A healthy tribal family provides support and encouragement to its members. Communication is crucial to its survival. The move from the

extended family to the single-parent family has made communication difficult. Relatives often live in separate homes or communities. The nurturing relationships that once existed between grandparents and grandchildren has disappeared. As a result, many children are not learning to respect older people, and older people are losing their ability to teach and nurture the young.

The healthy tribal family is an integrated whole. Everyone's role is well defined. Its values promote behaviour which reduces conflict and strengthens cooperation. It encourages children to recognize and value their gifts and abilities through totems, vision quests, fasts, sweats, and other ceremonies. Today, our children are confused about their purpose in life.

In the healthy tribal family, children are seen as gifts from the Creator, a valuable resource through which we can continue to exist. They are treasured, loved, protected, and nurtured by the entire extended family. Civilized society has placed all the parenting responsibility on a few caregivers. It has lost sight of the fact that children are gifts from the Creator. Our people have not learned healthy parenting skills in the residential schools, and, often, they have lost the ability to form healthy emotional connections.

In the healthy tribal family, children are taught to become independent. They are encouraged to take on new tasks as soon as they can. This produces self-reliant, self-confident adults. In civilized society today, parents often lack the knowledge and ability to teach their children this basic skill. This produces dependent adults with low self-esteem.

In the healthy tribal family, all members are encouraged to express their opinions and to listen to each other. They do not interfere with each other's actions, however, as this is a show of disrespect for the person's right to self-determination. In civilized society, there are many cases where the physically weaker person has virtually no rights.

The healthy tribal family separates the generations, while encouraging a flexibility in roles. The boundaries between infancy, childhood, young adulthood, parents, and older people are well defined and the transition from one stage to another is honoured in a community or family ceremony. However, there is also room for flexibility. A grandparent or an older child might temporarily assume the parenting role while the

parents are away. In civilized society today, the roles are poorly defined. Children perform parental functions and parents act like children. This confusion contributes to self-abuse and abuse of others.

The healthy tribal family grows in spite of and because of its problems. Troubles are seen as opportunities for growth. This has produced, in our people, the ability to survive numerous environmental challenges as well as the arrival of newcomers to our land.

The healthy tribal family can experience relationships inside and outside the family. It is important to develop a close-knit family unit. However, it is equally important to experience relationships with different families, clans, and tribes. In today's civilized society, many people lack a strong sense of cultural and personal identity, and they have lost the capacity for healthy exchange with others.

Our prophecies speak of a time when our people would meet the people of Europe. These teachings also say that the Europeans would introduce us to a new way of living, that we would lose our path for a while, and that we would experience a time of ill health, when many people would die prematurely. Our prophecies also speak of hope. They foretell a time of healing, a time when we will thrive once again to lead other races in our pursuit of earlier knowledge.

The tribal peoples of North America follow diverse paths today. The healthiest among them are those who have remained true to traditional tribal ways.

We need to incorporate the strengths of the tribal family and values into our lifestyle. We must stop the pattern of self-destruction that is all too familiar in our communities. We are lost between the tribal and civilized lifestyles, but if our prophecies are correct, we are on the path to healing and self-determination.

PANEL DISCUSSION

There has been an organizational shift from the extended family to the nuclear family to the single-parent family. The extended family is interdependent and holistic. Nuclear and single-parent families are based on power and control.

Today, we have four types of family structures:

Traditional: *Traditional values.*

Mixed: *Traditional values and western values.*

Assimilated: *Western values.*

Dysfunctional: *No values.*

Tribal ways may be healthier for our people than the civilized way of life, but we cannot return to former times. The suicide rate will not revert to what it was in tribal times. We need to identify those factors which promote healthier behaviour.

KEY ISSUES

- We need to learn more about the various mental disorders in our communities, while keeping in mind that the western framework does not always apply to the traditional Aboriginal experience.
- Our people have been strong enough to survive many hardships. We need to educate ourselves about the Aboriginal way of life.
- We must try to find equality and balance in our family relationships.
- Our children are gifts from the Creator, a valuable resource through which we can continue to exist. We need to encourage them to recognize and value their gifts and abilities.
- We must help our children on their way to becoming self-reliant, self-confident adults.
- We need to express ourselves and listen to each other.
- Everyone has a right to self-determination. We must not interfere with another person's actions.
- The healthy tribal family separates the generations, while encouraging a flexibility in roles. We need to respect each other's roles in the family, and yet be flexible enough to assume another role, if the need arises.
- We must enhance our capacity for healthy exchange with other families, clans, and tribes.

Communities and Culture at Risk – Searching for the Invisible

... by Stan Wilson, PhD and Peggy Wilson, PhD

"We need to learn about our values and traditions, those invisible forces that bind us together and keep us alive. They are not found in textbooks."

Like an iceberg, only one-tenth of our culture is visible. Skin colour, mannerisms, material artifacts, ceremonies, and language are part of the visible culture. What is invisible is our connection to our ancestry, our kinship and alliances, the values we express in our own language, the emotions we feel when living in harmony with nature, our sense of place and peace in the cosmos, our sense of responsibility in honouring Mother Earth, and our heredity. These invisible values and traditions are not taught in textbooks. They are lived.

In our tradition, the older generation teaches the younger generation about customs and rituals. They are strengthened through daily use, and they set the standards for how we interact, where we live, how we communicate, and how we behave. These invisible forces are taught and reinforced through example, by living with and near knowledgeable Elders, through spiritual guides, and through respected leaders. When any of these ingredients are absent or weak in a community, all of its members suffer. They become alienated from their cultural roots and look elsewhere for answers or quick fixes.

We often see education as the answer, but when we bring provincial curricula into Aboriginal settings, the invisible forces of our culture become even more elusive. When we bring teachers in from other cultures, we are giving our power away. They unwittingly spread their own culture. Our children become disheartened when education fails them. They become disinterested and undisciplined. They drop out, skip class, or are expelled. Often, outside experts are brought in to solve the problem.

Outside experts, who have not lived our indigenous culture, can do more harm than good. These experts may be mental health workers, psychologists, government agents, or spiritual leaders. They often diagnose phobias, disorders, and problems through the eyes of their own culture. Whether they realize it or not, they are biased, and the tools they use are biased.

Sudden wealth has become a dream for many people, but sudden wealth often leads to deepened despair and may even lead to suicide. When hopes are pinned on one answer alone, and that answer does not fulfill expectations, the results can be devastating. This has been evidenced in the oil-rich tribes of Canada and the United States. Sudden wealth does not give lasting cultural satisfaction.

Plastic Indians and Circuit Elders are terms used for some Indians who have come through alcoholism and, in their search for identity, have turned to a superficial display of Indianness. Often, they are known to be sexual abusers or wife batterers. They have no real understanding of our culture. Their preaching repels many young people who are looking for genuine, lived common knowledge. We need to turn to the more humble people in our communities, the Elders who maintain our traditions.

Adolescence is a difficult time in anyone's life. It is particularly difficult for Indian youth who have not been steeped in the tenets of their culture, and who have no secure sense of place and usefulness. Most suicides are committed by adolescents. The two most common causes of suicide are the rapid disintegration of traditional values and the breakdown of both the nuclear family and the extended family. When our young people experience the traditional ways of their grandparents, yet are driven toward another set of values, they develop fragile personal and cultural identities. Their difficult search for identity is made worse by the fact that their parents are also embroiled in the same struggle. However, the suicide rate for Indian children who are adopted by families outside their culture is even more alarming. It is reported to be twice that of the youth on reserves.

Some people leave their own culture behind and become part of another culture without much trouble. Some move back and forth between two cultures, and operate quite well in both. Others cannot fit into their adopted culture. This can be very traumatic, especially if they had previously rejected their own culture.

The void created by rejection, lack of understanding, or misunderstanding of the mother culture is sometimes referred to as a soul wound. It is a wound which can fester. When the search for healing answers comes from outside our culture, it often worsens the pain. We must not look for answers outside ourselves, our community, and our culture. We must solve our own problems. We need to find our own personal and cultural strengths. We need to learn about the invisible forces which drive our culture, connect us to the universe, and have made our peoples the keepers of the earth for a millennium.

With guidance from our Elders, we need to learn about the structure of our traditional society and about our roles and functions. Our family system and self-governance must support us in our roles. Everyone needs to feel that they are valued members of the community.

Our Elders tell us that the young people of today who question their cultural roots will be the true leaders of tomorrow. They will not accept pseudo-Indianness. They will drag their parents out of bingo halls and overthrow the self-gratifying political community leaders. We need to help, not hinder them. Those young people who survive will be strong. They will adapt and possess the survival skills of this generation. They will find the answers and they will pass these answers on to the next generation.

PANEL DISCUSSION

Many of the standards that Aboriginal people have accepted are sub-standard. They feel that they do not deserve a better life. This is the attitude of many homeless people and of some refugees.

In former times, we farmed the land on the reserves. When the government saw that we were prospering, they took over the financial management of our farms. They kept a large portion of our money for themselves and gave us just enough to survive. Some of our Aboriginal peoples seem to be stuck in this colonial frame of reference. Others are becoming autonomous. Only now have we begun to assert our right to self-determination. Being present at this conference is a miracle of survival. We must now reform our frame of reference by asking the appropriate questions.

The adolescents in our communities must be exposed to better things, to more positive environments, and especially to more traditional cultural information. We need to help them acquire the information they so desperately need. Suicide attempts by the young people in our communities are a response to serious feelings of rejection. We can all help with the parenting of such children. It is our responsibility to help our children grow into mature, self-reliant adults. We must not let them down.

KEY ISSUES

- When we bring teachers in from other cultures, we are giving our power away. We need teachers with our Native background and training.
- We need to teach our children and reinforce our teachings through example, and by introducing them to knowledgeable Elders, spiritual guides, and respected leaders.
- We must stop pinning our hopes on sudden wealth or other false expectations, which only cloud the issue and do not give cultural satisfaction.
- We need to reduce the influence of plastic Indians and circuit Elders, and an adherence to rigid religious sects.
- We must not look for answers outside ourselves, our communities, and our culture. We must solve our own problems. We need to find our own personal and cultural strengths.
- With the guidance of our Elders, we must learn more about the structure of our culture, about our roles and functions.
- Our adolescents need to be exposed to more positive traditional information. We must help them in their quest for knowledge.
- The community as a whole needs to help with the parenting of our youth. We are all responsible for our children.

NOTES

PART III

TREATMENT

WORKING WITH INDIVIDUALS

... by Deborah Faith Pace, PhD

"The longest journey in life that a person makes is the journey from his heart to his head. We must learn, think, and understand the emotions that our spirit feels."

As Natives, we have a different world view and understanding of life and death. We must not forget, however, that not all Native cultures and subgroups are the same. We share some common attributes, but every tribe is unique. Every tribe throughout North America speaks its own language or has its own dialect, and performs its own distinctive rituals and ceremonies. Every tribe has a different set of problems, and the reasons for suicide in communities vary. To be of any help, we must study our own individual community reserve separately and come up with our own made-to-measure diagnosis and prevention treatment.

Suicide is mysterious. We do not understand it and we often cannot pinpoint its cause. Depression, however, is a common mental state among suicidal people. They feel great sadness, apprehension, worthlessness, guilt, or shame. Often, they will have another psychological problem. Alcoholics, for example, may become depressed because of their inability to stop drinking, or by their lack of employment or education.

People who are chronically depressed feel blue, lose interest in activities and usual pastimes, sleep too much or too little, feel incapable of doing anything. They experience fatigue, a loss of energy, negative thoughts, and diminished concentration. They often stay away from friends and family, and want to be left alone. People with a major mood disorder are severely depressed. They experience extreme changes in mood, motivation, understanding, and behaviour. They often need to be hospitalized. When this is accompanied by hallucinations or delusions, it becomes a psychotic disorder.

Depressed people are unable to pay attention to what others are saying. They prefer to sit alone. Talking is too much work. They speak slowly and pause often. At times, they are agitated, unable to sit still. They will pace the floor, keep their heads down, sigh a lot, moan, and complain. They cannot find a solution to their problem. They may stop washing, changing clothes, or taking care of themselves completely. They will complain of aches and pains. They feel rejected, and have no hope of getting well.

Depression can affect children, adolescents, adults, and the elderly. Children who are depressed may become overly active, aggressive, and whiny. Adolescents may have constant negative thoughts, break society's rules, and feel that no one understands or accepts them. The adult may have a loss of memory and act distracted.

Native people may find it hard to share their feelings with others or to seek professional help. Professional crisis workers are not readily available on reserves. Many people do not have telephones, and they live far away from their neighbours. They do not know where to look for help. Some may be afraid and ashamed of their feelings of depression, and fearful of being labeled crazy. Children may have difficulty reaching out to their parents, who spend their time in bingo halls and bars. A generation ago, most parents were still in residential boarding schools, where they lost their parenting skills.

On average, depression will last four to six months if left untreated. It is a very scary feeling. The pain is enormous and very frightening. The person feels that the only way out is to end his or her life.

We need to accept that there are problems in our own communities, and we must agree to do something about them. We often turn away and refuse to see suicide as a problem in our community. We are burdened with so many other problems, at times, that we need all our energy just to survive on a personal level. Taking on the whole community's woes may seem to be too much. The path of healing, however, begins with cultural unity and strength.

We must not accept treatment which is based on western medicine as the only alternative. We do not need non-Native experts, who do not fully understand our culture, treating our emotional pain. This type of treatment was developed for non-Natives and is not necessarily good for Native people. We are the experts in our own communities. We know

our needs. We have our own sophisticated methods of treatment in our sweats, lodges, sundances, and herbal medicines. We have to reexamine, repair, and rebuild our roles in the cultures of our tribes. Too many of us have tried to assimilate into other cultures unsuccessfully.

"If the shoe does not fit, take it off and try the moccasin."

Once our community members stop denying that a problem exists, we can start to treat many problems, some of which have led to suicide. The Chief and council members must be committed to and involved in the treatment and prevention of suicide. They must convey a message of caring and concern. This may sound too simple, but it has a tremendous impact on the reserve. Chief Roy Fox from the Blood Reserve, for example, made an effort to learn more about Fetal Alcohol Syndrome. He attended workshops and conferences. Community members, as a result, formed a research team. Now, there is an early intervention program, which was started with the help of community Elders, parents, teachers, and other professionals.

We need to get off the path of learned helplessness. We need to stop being victims. We can only do this by understanding our history, becoming aware of the problems in our communities, educating others, owning the problems as a whole, and developing our own treatments.

PANEL DISCUSSION

Aboriginal parents were obliged to send their children to residential boarding schools. If they refused to comply, they were jailed and their children were sent away to school anyway.

Today, we are living with the results of this measure. Parenting skills were lost in residential schools. They must be taught. At times, the products of these schools, our parents, have so many problems of their own that they have no energy left for anyone else in the community.

Our family and community structures and boundaries are not well defined. Today, many individuals do not agree with or subscribe to the community as a whole. They feel guilt and shame because they cannot express themselves about this. We need to be flexible and tolerant so that people can open up and find their own ways of living.

Suicide is a community problem. It affects everyone, and it is a source of great trauma. We need to deal with the trauma by putting our feelings into words. Words can be magical. We need to listen more closely to our families, friends, and neighbours. We must communicate our caring. We must open up our hearts to those who are in pain. We also need to communicate our own pain to those we love and trust. Only through working together can we become strong, and continue to exist as closely-knit and powerful communities.

KEY ISSUES

- We need to study our own community separately, and come up with our own answers.
- The path of healing begins with cultural unity and strength. We need to accept that there is a problem in our own community, and we must agree to do something about it. That is the first step on the path to healing.
- We have our own methods of treatment. Our sweats, lodges, sundances, and herbal medicines can help us reexamine, repair, and rebuild our roles in our communities.
- The Chief and council members must be committed to and involved in the treatment and prevention of suicide. They need to convey a message of caring and concern.
- We need to stop being victims, get off the path of learned helplessness. We must learn about our history and become aware of the problems that exist in our community.
- We need to educate others. Only in this way can we educate ourselves.
- We need to work on our problems as a community and develop our own treatments and cures.
- Parenting skills must be taught. They were lost in residential schools.
- Our family and social structures are not well defined. We must strive to develop our own community structures and boundaries.
- We need to be flexible and tolerant of other people so that they can open up and find their own ways of living and doing things.

WORKING WITH FAMILIES

... by Joan Glode, MSW

"Suicide among Native people is a symptom of loss, grief, and anger. An adequate response must entail an overall healing strategy."

Residential schools and the child welfare programs contributed, over the generations, to the disintegration of family life on the reserve. Growing up in residential schools was not uniformly bad, but it did extensive damage to feelings of self-worth and family connectedness. The transfer of skills and traditions from one generation to another was all but lost. Residential schools fractured the core of trust and respect for others, from which all people must draw to build loving and healthy relationships and communities.

Many Aboriginal youth feel socially and psychologically isolated. They feel that their families and communities do not care for them. Their parents and grandparents learned and experienced unacceptable ways of living. Now, they are unable to teach what they have never been taught.

The Royal Commission Report on Aboriginal Peoples recognized that we must support the family, and it lists seven elements that are necessary for developing effective local family programs. These are:

1. Revitalize cultural and spiritual ties.
2. Strengthen the bonds of family and community.
3. Focus on children and youth.
4. Inspire a holistic way of living.
5. Involve the whole community.
6. Promote partnership among communities.
7. Develop strong community control.

We need to work with families in a holistic manner. We must intervene when there is a suicide crisis, but we must also do our best to prevent suicide from happening, by developing effective programs and services.

All Aboriginal communities are at very different stages of development, training, and education. Some communities have access to outside programs and services. Others do not. We need to develop programs and services that are compatible with our community values. The healing and therapy issues must be described in terms that are acceptable to the community. Therapy, as described by one community, is "the work of developing a vision that balances hope with limitations". Healing, on the other hand, is described as "a journey or a path to achieve a life of balance and harmony".

We need to find out if therapists or healers are available in our own communities. We must identify the resources available to us from outside our communities, and contact them to forge lasting partnerships. We must ensure, however, that outside workers are culturally sensitive to our Aboriginal needs. The suicide-prevention programs that we start today must be maintained, changed, and strengthened tomorrow.

As a community, we need to determine what we mean by family, and we must develop an appropriate code of ethics and values. We need to discuss our strengths and limits.

Families who are in trouble would do well to seek help from trained professionals. They must get past blaming each other and move on toward solving their problems. The role of the professional must be to help them negotiate a new contract.

Traditional values and culture will provide direction for programs and services. Communities know what they need and, with encouragement, they will develop their own responses.

PANEL DISCUSSION

There is some good reading material on suicide prevention, but reading material is not always available in our communities. Our people are information poor and time rich. People in cities are information rich and time poor.

We need parenting workshops. We must focus on prevention, not on crisis intervention. In therapy, it is difficult to separate the individual, the family, and the community. We must begin with the individual, but the individual is an integral part of the family, and the family is an integral part of the community.

We need to link the troubled person with a support network or with another caring human being, who is not necessarily a trained professional.

KEY ISSUES

- We need to build up our core of trust and respect for others, so we can have healthy and loving relationships and diminish the risk of suicide in our communities.
- We must search out our cultural and spiritual ties, for they are our strength.
- The community needs to work together to combat suicide in all its forms.
- We need to focus on our children and our young people, who are lost and in search of guidance. The community, as a whole, must play a part in their lives.
- We need to find out more about the culture of our ancestors. This will be our guide.
- The community must be involved as a whole in the everyday life of each and every one of us. Only then will we be able to determine who is at risk for suicide.
- We need to promote partnership among our peoples. United we stand, divided we fall.
- Our community governance must be strong. We must elect strong and wise individuals as Chief and council.
- We need to develop effective suicide-prevention programs and services that are compatible with our community values.
- We must identify the resources available to us in the community and outside the community. We can then contact outside people to forge lasting partnerships. *(cont'd)*

- **We need parenting workshops and crisis intervention. These are not mutually exclusive. In fact, the holistic approach must always be used when dealing with any community problem.**

- **We need to link the troubled people in our community with a support group or network, or with another caring human being. We do not need trained professionals to administer kindness and understanding.**

WORKING WITH COMMUNITIES

... by Arnold Devlin, MA

"A Native community crisis-response team can provide immediate, culturally-relevant support to the family and friends of suicide victims, in their own Native language."

The Nodin Counselling Service is a First Nations mental health program, which provides help to 28 communities within the Sioux Lookout Zone of the Nishnawbe-Aski Nation in Northwestern Ontario. These 28 communities, with populations ranging from 75 to 1600 people, have been plagued by a suicide epidemic for over a decade. During that time, there have been 106 suicides. For the past few years, there have been over 200 known suicide attempts every year. In one community of 1600 people, there were 19 suicides. In another community of only 200 people, there were 11 suicides.

When suicide occurs in a First Nations community, it has a devastating effect on all community members. It triggers a cluster of attempts, or it increases self-destructive behaviour such as alcohol or solvent abuse. People who have unresolved problems as a result of sexual abuse or family violence relive their pain and hurt. Community-based caregivers must respond immediately to the needs of the surviving family and friends.

The Nodin Counselling Service developed the Nodin Suicide Crisis Intervention Model, but found that one single model could not be used in every community. Some communities are traditional, while others are very Christian. Each community has its own history of trauma, loss, and grief.

To develop a community crisis-response team, everyone must act together: the Chief, the band council, the education authority (including teachers), the nursing staff, the band constables or police, the religious leaders (both traditional and Christian), the child welfare workers, the NNADAP, the mental health workers, youth groups, women's groups, and the Elders. There must be a climate of caring and concern.

The community crisis-response team provides immediate culturally-relevant support to people in their own Native language. The team must be made up of natural helpers and good listeners, who do not judge others, and are trustworthy. They may have lost a relative or friend to suicide themselves.

The team needs a leader, experienced helpers, people who are wise and caring, people who have knowledge of life-saving skills, and cooks and drivers. Everyone should be assigned jobs that they can handle. The team should establish a centrally-located base of operations. It can be in the public health room at the Nursing Station or in a meeting room at the Band Office, for instance.

The CHR or nurse will need to compile a list of suicide-survivor family members and friends, and make special note of those people who are known to be self-destructive. The team leader will then need to assign the names on this list to team members. Team members with experience should deal with people who are suicidal.

Team members should be prepared to do housework, look after children, and stay with the grieving family at night. They can help out with prayer or song. They should ensure the security and safety of the family, and display culturally appropriate caring practices. People who are grieving may voice strong feelings of anger, blame, and guilt. Team members do not have to say anything. They are there to listen, not to judge or give advice.

The crisis team may patrol the community and report self-destructive behaviour, such as alcohol abuse or solvent use, to the team leader, the band constable, or the police. They must stay in groups of two or three, and carry flashlights, two-way radios, and portable first-aid kits. They must not intervene in any situation that may place them in danger.

A community map ought to be made, if none exists. The map should display the various clusters of houses, indicate who lives in what house, show the school, businesses, nursing station, police station, craft store, band office, and hotel/motel. It should also indicate where the outdoor arena, playing fields, dump, and airport are located, and outline the roads, river or lake front, and government dock. The map should be photocopied and distributed to all team members. The places where young people go to drink or sniff gas should be identified on the map. There are places in communities where people frequently go to commit

suicide. These should be specified and patrolled frequently by the police and the crisis team.

Each team member should sign an oath of confidentiality. There must be clear guidelines and procedures for disclosure of sexual abuse or family violence. The team leader needs to be available at all times for reporting and sharing of information.

There must be guided group interaction among members of the team. They need to air their thoughts and feelings with each other in a structured environment. Reactions can vary greatly, but they are all normal human reactions to abnormal events. Care for the caregivers is a crucial element in the crisis-response team.

Mental health counsellors play an important role in supporting the crisis team. A suicidal person may be referred to a mental health counsellor by a team member. The counsellor assesses the level of suicide risk and develops a plan of action. As more people are observed, assessed, and treated, the need for suicide intervention may decrease.

The Nodin Counselling Service has been in place for five years now. The suicide rate has not decreased, so far. Bringing in Native physicians has helped enormously. It has provided a sense of support, knowledge, and leadership. One day, we hope to see a marked change in our communities. The healing process has only begun.

PANEL DISCUSSION

When the Nodin Counselling Service comes into a community, the community is ready to accept help. It takes the available information and reshapes it to fit its own experience. Any intervention mirrors the community's way of thinking. Bringing in people from outside the community is not a foreign idea. Native people have traditionally reached out to others during time of death.

We need to develop a general protocol for crisis situations on reserves. However, the community as a whole is not always easy to mobilize. A few people need to act as catalysts and motivate the rest of the community. Some communities have already developed first-response teams.

KEY ISSUES

- **Community-based caregivers must respond immediately to the needs of the surviving family and friends when suicide occurs.**
- **The community must act together to develop a community crisis-response team, and create a climate of caring and concern.**
- **The community crisis-response team must consist of natural helpers and good listeners, who do not judge others.**
- **The crisis team needs a leader, experienced helpers, people who are wise and caring, people who have knowledge of life-saving skills, and cooks and drivers. Its base of operations should be centrally-located.**
- **The CHR or nurse needs to compile a list of family members and friends, and make special note of those people who are known to be self-destructive.**
- **Team members should be prepared to do housework, look after children, and stay with the grieving family at night.**
- **In a crisis situation, team members are there to listen, not to judge or give advice.**
- **The crisis team may patrol the community and report self-destructive behaviour, but they must not intervene in a dangerous situation.**
- **A community map should be drawn up, if none exists. The map must indicate the places where young people go to drink or sniff gas. It must also indicate the places where people frequently go to commit suicide.** *(cont'd)*

- **The team leader needs to be available at all times for the reporting and sharing of information.**
- **Care for the caregivers is crucial. There must be guided group interaction among members of the crisis team.**
- **Mental health counsellors play a vital role in supporting the crisis intervention team. As more people are observed, assessed, and treated, the need for suicide prevention may decrease.**
- **Any intervention must mirror the community's way of thinking.**
- **A small group must act as the catalyst and motivate the rest of the community.**

NOTES

PART IV

CLOSING REMARKS AND RECOMMENDATIONS

Closing Remarks

... by Vincent Tookenay, MD

Our audience is the front-line worker in the community. We need to provide appropriate resources to help that worker in whatever way we can.

We should keep in mind that this is only the beginning of a long journey into bridging the communication gap. There is a pressing need for regional data.

It would be helpful to have periodic discussions on various topics that are of importance to our Native communities. We can begin by establishing one group to share ideas and link up with other groups everywhere across the country.

We must realize that we share a collective grief. We can rejuvenate the infrastructures in our communities, and we need to support the development of leadership.

RECOMMENDATIONS

... by Elsie Cassaway, BA,
Assembly of First Nations

This handbook is a beginning, but it should be developed and adapted within each community. That is our intention. We would hope that each community will add and amend some, or all, parts of this document. Only in this way will it be effective as a tool for suicide prevention.

We need to keep in mind the holistic approach, and the holistic principles of mind, body, and soul. Everyone in every community must be involved and interested in suicide prevention. Most importantly, we need to listen to each other and to find ways of working together in a spirit of cooperation and renewal.

PART V

APPENDICES

APPENDIX A

Suggested Readings on Suicide Prevention

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APPENDIX B

Presenters, Organizers, and Participants

PRESENTERS

Margaret Sebescen, BA,
1118 Lee Blvd., Winnipeg, Manitoba, R3T 2P4

Charles Mustard, MD, and **Ellen Bobet, MA,**
Jeanne Mance Building, Tunney's Pasture, Ottawa, Ontario, K1A 0L3

Brenda Restoule, MA,
263 Sunrise Crescent, Kingston, Ontario, K7M 8C5

Dianne Tanner, MA,
Suite 405, 225 Metcalfe St., Ottawa, Ontario, K2P 1P9

Bruce Handley, PhD,
303 - 4822 50th St., Red Deer, Alberta, T4N 1X4

Edward Connors, PhD,
Chippewas of Rama, Health Centre, Box 35, Rama, Ontario, L0K 1T0

Stan Wilson, PhD, and **Peggy Wilson, PhD,**
Opaskwayak Cree Nation, Box 2713, The Pas, Manitoba, R9A 1M5

Deborah Pace, PhD,
Apt. 2001, 11135 - 83 Ave., Edmonton, Alberta, T6G 0V1

Joan Glode, MSW,
Box 179, Hants County, Shubenacadie, Nova Scotia, B0N 2H0

Arnold Devlin, MA,
Box 968, Sioux Lookout, Ontario, P8T 1B3

Organizers

Art Blue, PhD, Conference Leader,
Open Arrow Clinic, Box 1020, Carberry, Manitoba, R0C 0H0

Marie Ross, BA, RN, Conference Chairperson,
Jeanne Mance Building, Tunney's Pasture, Ottawa, Ontario, K1A 0L3

Participants

Elsie Cassaway, BA, Assembly of First Nations,
55 Murray Street, 5th Floor, Ottawa, Ontario, K1N 5M3

Vincent Tookenay, MD, Native Physicians of Canada,
1867 Alta Vista Drive, Ottawa, Ontario, K1G 3Y6